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THIS ISSUE OF "FLORIDA HEALTH NOTES" DISCUSSES FLORIDA'S MIGRANTS AND THE MIGRANT HEALTH SERVICES PROVIDED BY THE STATE BOARD OF HEALTH AND THE COUNTY HEALTH DEPARTMENTS. THE FOLLOWING TOPICS ARE DISCUSSED--THEIR HOUSING AND SANITATION FACILITIES, THEIR LONG WORKING HOURS AND LOW WAGES, THEIR SUMMER MIGRATION PATTERNS, THEIR HEALTH PROBLEMS, AND FACTORS LEADING TO THEIR MIGRANCY. FLORIDA IS ATTEMPTING TO ASSIST THE MIGRANTS BY PROVIDING--HEALTH SERVICES THROUGH THE CHRISTIAN MIGRANT MINISTRY, IMPROVED HOSPITALIZATION PROGRAMS, THE STATE'S MIGRANT HEALTH PROJECT, MAKING PUBLIC HEALTH NURSES, PHYSICIANS, SANITARIANS, HEALTH EDUCATORS, SOCIAL WORKERS, NUTRITIONISTS, CLINIC-AIDES, EQUIPMENT, AND MEDICATIONS AVAILABLE FOR THIRTEEN COUNTIES, AND THE HEALTH INDEX REFERRAL SYSTEM, FOR TRANSFERRING HEALTH SERVICES INFORMATION FROM COUNTY TO COUNTY OR FROM STATE TO STATE. FLORIDA HAS A MIGRANT HEALTH COORDINATOR TO ORGANIZE THE ACTIVITIES OF THE STATE BOARD OF HEALTH AND THE COUNTY DEPARTMENTS WITH THE WORK OF OTHER AGENCIES AND ORGANIZATIONS. THE PUBLICATION CONCLUDES THAT A MAJOR HEALTH SERVICES PROBLEM IS GETTING THE MIGRANTS TO AVAIL THEMSELVES OF THE SERVICES THAT ARE PRESENTLY PROVIDED. THIS ARTICLE IS PUBLISHED IN "FLORIDA HEALTH NOTES," VOLUME 57, NUMBER 7, SEPTEMBER 1965. (RB)

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FLORIDA HEALTH NOTES

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Better Health for Migrants

BETTER

Most of the work done by migrants, such as harvesting beans, is "stoop labor."

HEALTH

FOR

MIGRANTS

There are approximately 100,000 persons who drift into Florida early each winter along with the first chilly breezes. They're not tourists. They sometimes don't know where they will get their next meal. They may live in tents, shacks or packing boxes without adequate sanitary facilities. They have very little money, education or hope. Yet, millions of dollars of Florida's economic wealth are dependent upon them. **These people are migrants.**

Migrants are people who earn their living by harvesting crops in different states at different seasons of the year. Each winter millions of dollars worth of truck and citrus crops and sugar cane mature in South and Central Florida. If agricultural workers were not available in sufficient numbers, beans would spoil on the vines; tomatoes, celery and potatoes would rot; and oranges and other citrus would become over-ripe. There would be a shortage of fresh fruits and vegetables for the nation's markets, and businessmen in many of Florida's communities would lose a great amount of money.

While migrants are needed by Florida's economy, they suffer the disadvantages of a mobile existence. Some of these disadvantages are

the lack of medical care, good housekeeping, adequate diet and continued schooling for children. These people face long journeys in unsafe vehicles, long hours with low pay and an uncertain future. This issue of **Florida Health Notes** will tell you about migrants and what the State Board of Health and the County Health Departments are doing to assist these people to better health and an improved way of life.

BECOMING A MIGRANT

There are several reasons why people are migrants. Most of them were at one time agricultural workers from the rural South. But they lost their jobs in their home communities because the land could no longer support them, farms on which they worked became mechanized or were sold, or the land was placed in the soil bank. Other persons (especially young people) became migrants simply because there was no work at home. Other sharecroppers became migrants because they had heard about the "fast life" the migrants lived or because they preferred the nomadic way of life.

Let's take as an example a typical migrant family--the Miggs.

The family, composed of a father, mother, two teenage sons, several smaller children and a niece, left their home in a southeastern state and joined the migrant stream because the farm which they worked as tenants could no longer support them. When they heard from a labor recruiter that they could "make $25 to $30 in a few hours picking beans," they packed their few belongings in the old truck and set out for Florida. Once in the Sunshine State, they found their dreams of sudden wealth vanish. Work and housing were scarce, and the Miggs discovered themselves stranded in South Florida with little money and only day work available.

FLORIDA HEALTH NOTES

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Most of the migrants who come to Florida each winter are Negroes. There are also a number of Mexican-Americans from Texas, Puerto Ricans, American whites and several thousand workers from British West Indies who are brought into Florida under contract to harvest such specific crops as sugar cane.

Most of the migrants have little formal education. Many are illiterate while a few finished elementary school or attended high school. Because of the lack of an education, migrants find themselves not capable of understanding the numerous problems they meet; they are unable to find work that would bring an adequate wage; and they are helpless to lift themselves out of the hand-to-mouth existence in which they are trapped.

Lacking adequate facilities, this migrant mother washes her youngster's head in a galvanized tub.

LONG HOURS AND LITTLE PAY

When the Miggs became migrants, they had no idea of the rigorous work they would find in the bean fields. Whereas they had worked for one man back in their hometown and found some degree of dependency and security, they found as migrant laborers they seldom worked for one grower for any extended length of time.

Most of the work is stoop labor—harvesting beans, celery, peppers, tomatoes, strawberries, etc. The harvesting of crops and the amount of work available to the Miggs and other migrants are dependent upon the market price the grower can get for his produce **and the weather.** If the grower is liable to lose money by harvesting his crops, he may plow them under. Crop failure due to drought, freeze or blight could wipe out all hope of work for the migrants and their meager income would be even less. A surplus of workers may also force down the migrants' earnings.

After a long day, migrants line up to receive their pay.

The Miggs work long hours. The father, mother, older sons and some of the younger children are in the fields when the sun comes up and often do not return to their temporary home until night. The niece stays with the very young children. While working in the Lake Okeechobee area, members of the family work on a day-by-day basis. Each morning at 6 o'clock they go to the loading zone in Belle Glade where they hear the truck and bus drivers shout the wages the growers are paying that day to harvest vegetables. Once they have decided what they want to pick, the Miggs climb aboard the vehicle and head for the fields.

Low wages are a part of the migrants' life. During an average day, they can make from $7.00 to $8.00. Harvesting celery may bring about $1.00 a row; bush beans pay 70 cents a hamper; sweet corn, seven cents a package; tomatoes, 14 cents a ⅝ bushel bucket; and citrus, 20 to 25 cents a box. When they are working dayhaul in Florida, the migrants pay 50 cents for transportation to the fields. Sometimes when they arrive in the fields, the harvest is so light that the migrant can barely pay for his transportation and lunch.

NORTH IN THE SUMMER

When the season ends in Florida—May or June—the migrants begin to head North through the Atlantic Coast states. One year the Miggs signed up with a labor crew leader who had negotiated contracts with growers in Virginia, New Jersey, Pennsylvania and New York who had crops to be harvested. The crew leader tried to enlist all of the needed labor before leaving Florida. He had such duties as transporting the crew north in an old bus, settling arguments within the group, handling difficulties with outsiders, trucking workers to the field, supervising the paying of wages and acting as adviser to the families in his crew.

Another year the Miggs migrated North on their own. This trip was not satisfactory, because their old truck broke down several times en route and work was not easily forthcoming. Some of the migrants can make money on their summer trips north but many times, due to

accidents and misfortune, they arrive back in Florida with less money than when they started.

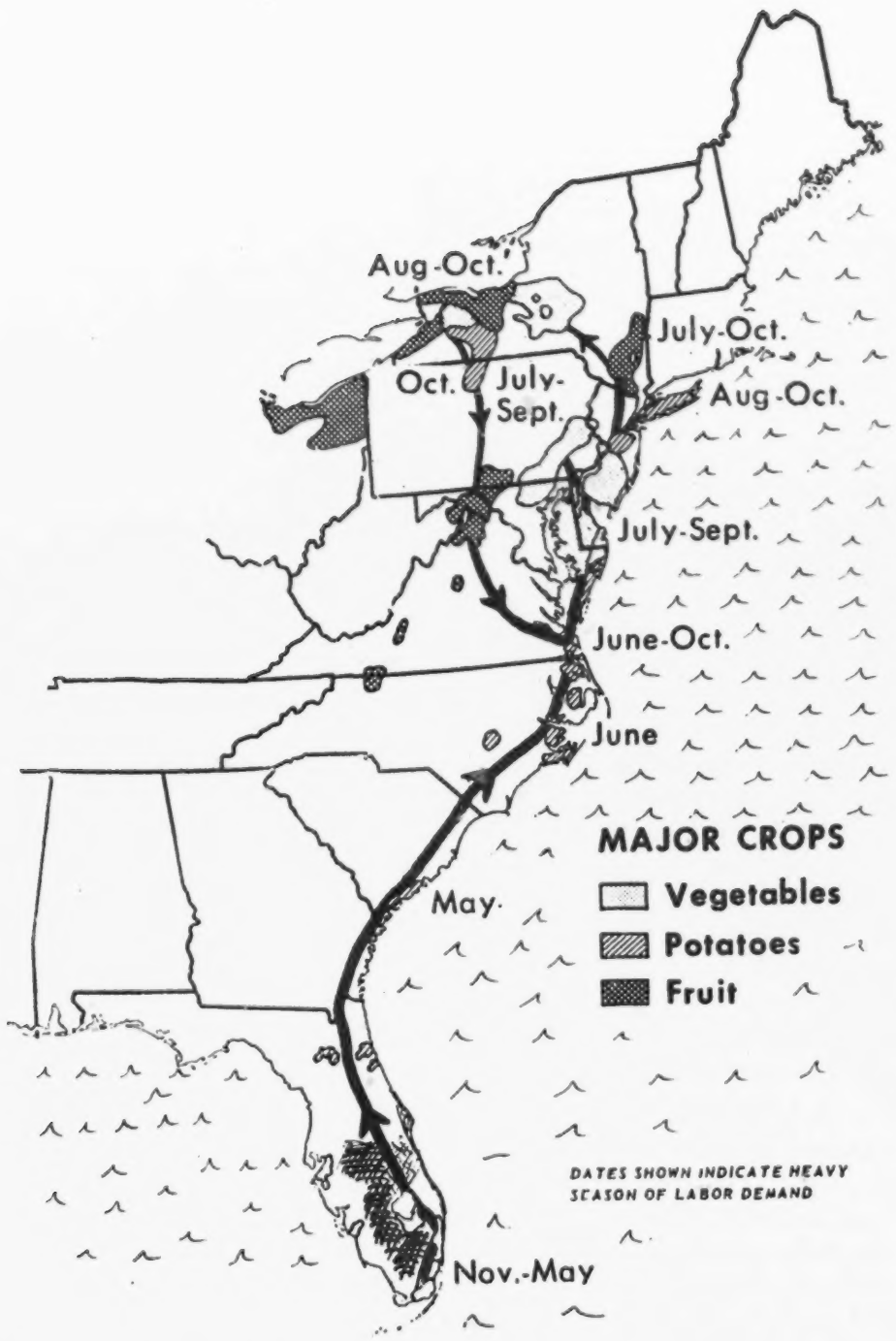
The Miggs spend about six to eight months in South Florida where the land is fertile and the season long enough for the farmers to grow three or more crops a year. May and June find them harvesting strawberries and potatoes in the Carolinas. From July through October they pick truck vegetables and fruit in Virginia, New Jersey, Maryland, New York, Pennsylvania and West Virginia. Late in October, the Miggs head for Florida, but often there is no work for several weeks. Because of the interstate nature of their migration, the Miggs are the residents of no particular city, county or state. They are considered ineligible for many benefits the permanent residents receive. The lack of legal residence does not keep the Miggs from placing their children in school or receiving public health services, but they are not able to qualify for welfare assistance and other social benefits. The Miggs and other migrants are often considered a "necessary evil" by many local people—yet they are needed in the flourishing community.

PEOPLE IN NEED

Because they are in a location for only a short time, the Miggs family develops few community ties and takes no interest in the community. They may know the man from whom they buy their food, the grower for whom they work and the local bartender who sells them cheap wine.

Migrants often don't know when they should seek medical assistance. They work long hours and are tired at the end of the day. They seek help only when they see blood or when they "feel" sick. They may not feel sick and therefore they cannot understand that hookworms or roundworms are harmful to them—because they can't see the parasites. Diarrhea, infections and respiratory diseases are common among these people.

Proper medical care is something the Miggs have never been able to afford. If one of the family has a cold or an illness not requiring hospitalization, Mr. Miggs may seek help from the crew leader or the



After spending the winter in Florida, the migrants move north along the Atlantic Coast to harvest other crops.

Offshore workers (left) cut sugar cane in a burned-over field. They live in barracks (above) which are provided by the grower. These differ from the average migrant family housing.

Offshore Laborers

Each year about 8000 to 14,000 workers are brought into Florida from the British West Indies to harvest such crops as sugar cane or tropical fruit. The work of cutting cane is particularly arduous and calls for skills which many of the American migrants do not have. Therefore, growers bring in men under contract with the British government. The contracts require good medical care, proper housing and sanitary facilities for the men, and the County Health Departments and the State Board of Health cooperate in inspecting and licensing the facilities for these workers.

farmer for whom he is working. If these men are properly informed and can give the right information, Mr. Miggs may take the sick member to the public health clinic. Or the Miggs may learn of the clinic by the "grapevine." But sometimes this form of communication breaks down and the migrants will misunderstand who is eligible to attend the clinic or the purpose for which it is held. Once the Miggs have been to the clinic and lose their fears of doctors and nurses, they may go back when they are sick or "need to talk to someone."

The Miggs suffer from lack of proper foods. They don't know about balanced diets, nutrition, etc. Many of them have no experience in cooking the vegetables they harvest. Shortage of space and limited equipment in their quarters make adequate preparation of food almost impossible. Mrs. Miggs usually serves fried fish, grits, collards and bread for breakfast. Food in the fields may consist of a meat sandwich and a bottled soft drink purchased from a lunch truck. When she returns from the fields in the evening, Mrs. Miggs usually is so tired that the late meal consists of canned foods and soft drinks.

The children, if they are not in school, eat breakfast leftovers or have nothing between breakfast and supper. Daily trips to the store are necessary because of the lack of a refrigerator; the only cooking utensils are a couple of frying pans; and the stove is a two-burner hotplate or kerosene stove. If the Miggs do not have money to buy food when in the Belle Glade area, they live on fish from the canals and abandoned vegetables from the fields.

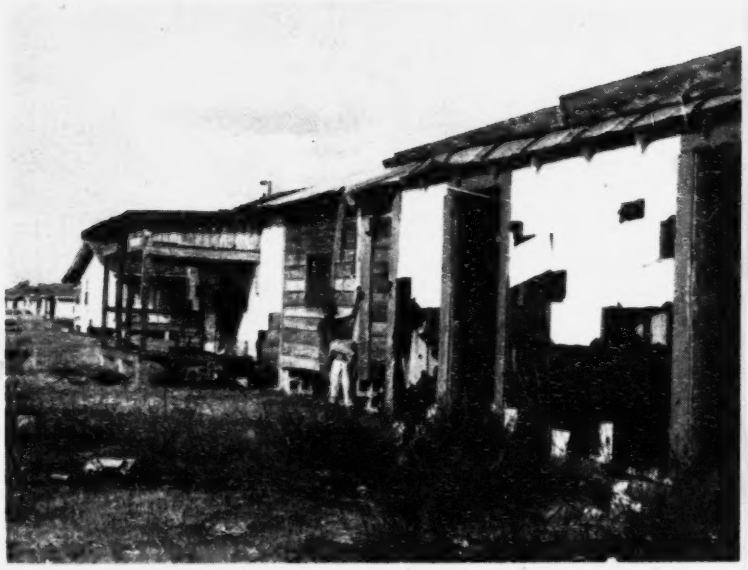
MIGRANT HOUSING AND SANITATION

Migrant housing has continually improved over the years through the coordinated efforts of the County Health Department and the State Board of Health. For some 20 years, sanitarians have worked on upgrading migrant camps but until the licensing law was passed in 1959 enforcement activities were very limited and improvements were difficult to obtain. Now the County Health Departments and the State Board of Health are authorized to inspect and license camps which house 15 or more migrants. Another state agency (the Hotel and Restaurant Commission) licenses such places as migrants' boarding

houses. In 1964, there were 247 licensed camps in Florida as compared with 167 such camps in 1960.

Plans for new or renovated camps are approved by the County Health Departments. The new camps may include bathroom facilities for the exclusive use of each household. Adequate space, good lighting and ventilation and safe water supplies are provided. A few camps are installing sewage treatment plants which are approved by the State Board of Health.

Living quarters can be very poor where they are not required to be licensed, where camps are illegally operated or where local ordinances are not enforced. Dwelling space may be limited; families large; and most of the families have only one or two rooms. When the Miggs are late in arriving in Florida, the better housing is taken and they have to live in condemned housing, tarpaper shacks along the canals, in the remote canebrake or even in packing boxes. If there are cracks in the floors, walls or ceilings, the migrants stuff them with newspapers or line the walls with pasteboard cartons. When the Miggs move into such places, they are often ordered to move by the landowner, County Health Department sanitarian or the police.



The modern farm camp (above) is a great improvement over the condemned living quarters of some migrant families (right). Behind these homes were piles of rubbish (opposite page).

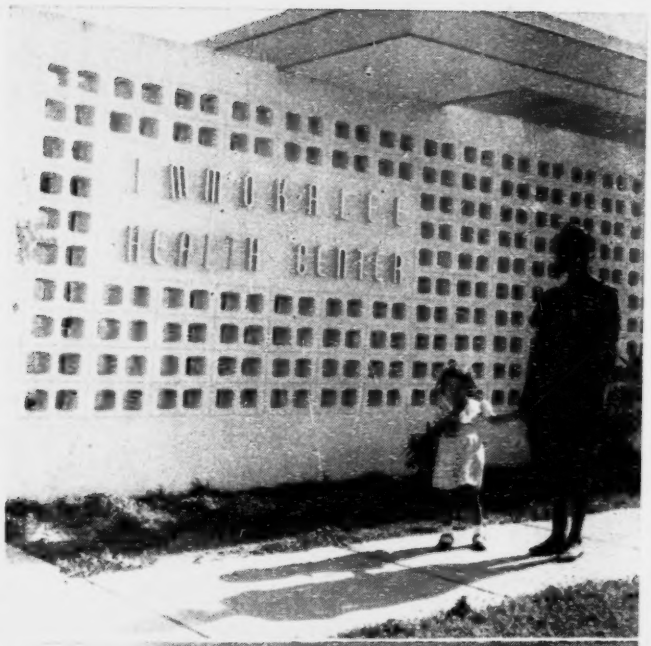
Since the Miggs left their farm home, they have been in the migrant stream for several years. They would like to settle down and call a place "home," but have neither money nor the knowledge of how to get out of the stream. Each year they come back to Florida with hopes of staying, but in the spring they hear about the offers to pick vegetables "up North" and they join a crew heading up the Atlantic Coast.

HELP FOR THE MIGRANTS

Migrants have health problems that are common in every low socioeconomic group plus a few that are exaggerated by their nomadic

MIGRANT CLINICS

Clinics for migrants are held in a variet and health centers (above). A migr for the records (left); a social worker t amines a young patient in a trailer clini at the Immokalee Health Center (right in a prenatal clinic. Another mother has County mission (below).



y of places, such as trailers, outdoors
ınt family gives a clerk information
ılks to a young mother; a physician ex-
c (below left). The waiting room is full
and an expectant mother is examined
her chest checked at a clinic in a Lee

way of life. They need medical and welfare assistance at times—no matter in which state in the Atlantic Coast migrant stream they might be working. Because such assistance has not always been available to nonresidents or because the migrants don't know where to go for help, they are often ignored. For years everybody knew the migrant health issue was a pressing problem. Some of the County Health Departments and the State Board of Health were trying to do something about it.

An intensive study of the migrant problem was begun about 10 years ago when the Children's Bureau of the U. S. Department of Health, Education, and Welfare began financing a program which supplied health services for migrants in Palm Beach County. A few physicians, public health nurses, sanitarians, social workers, nutritionists and a health educator worked on the pilot project to see what could be done for these unfortunate people. Other programs, involving a few public health nurses and sanitarians, were being carried on in Collier, Dade and Broward Counties.

Immunizations were given to children; mothers received prenatal and postpartum care; families were given physical check-ups (including chest X rays and such laboratory tests as urinalysis, stool examinations and serologic tests for syphilis). A plan for the delivery of babies in a hospital was worked out at a price migrant women could afford.

UNDERSTANDING THE MIGRANT

Despite years of working with the migrants, public health workers find they really know little about how a migrant thinks and acts. In many instances, methods which have worked with other groups have only alienated the migrants.

One of the problems involved in working with the migrants is their short residency in the state. Because they may move to another town—or even state—without notifying anyone, public health workers find that it is nearly impossible to determine what medical care the migrants have received. At one time, attractive plastic bags were given to migrants in which they were to keep their birth, health and school rec-

ords, insurance policies and other documents. However, the migrants started using these bags for diapers instead of preserving records.

Even where there is no language barrier, communicating with migrants is not easy. Public health workers find that migrants tend to give answers they feel the public health worker wants, and this makes it difficult to get the true feeling and accurate response of the migrants. Often the meaning of a question asked by the public health nurse is misinterpreted by the migrant because the two have different backgrounds and experiences.

A migrant woman may be asked, "How many children do you have?"

She may reply, "Six!"

But some of her children may be living with relatives and not counted as part of the six, and the woman may include some who live with her but are not her own children.

Where there is a language barrier (as with the Spanish-speaking migrants), the County Health Departments often have an interpreter who works with the physician or nurse.

There are many health and other services available to the Miggs family and other migrants in Florida today through the coordinated efforts of community groups, the Christian Migrant Ministry, some of the County Health Departments, the State Board of Health and other state agencies (such as the Florida Employment Service) and the U.S. Public Health Service and other federal agencies and programs (like the Economic Opportunity Act).

The Christian Migrant Ministry, which is composed of a number of church groups, operates a day care center in Immokalee, takes an interest in legislation affecting migrants and provides emergency assistance during crop failures. The Florida Employment Service helps the migrants to find work. The Economic Opportunity Act, among other activities, is being set up to develop programs which will educate illiterate migrants, provide day care centers for children and promote better housing and sanitation through low interest loans.

Migrants do not plan in detail, and there are few situations in which migrants plan beyond the present or immediate future. They can be assisted in preparing for the future, and often a public health nurse or social worker has to help a pregnant migrant woman plan for the delivery and care of her baby.

In addition to the lack of "knowing" the migrants because of their mobile status and communications barriers, public health workers have difficulty in getting the migrants to accept health services which are available. They work long hours for low pay and cannot afford to stop work to attend a day clinic. Migrant women cannot bring their babies in one day to attend a well-baby clinic and then come back another day for a prenatal clinic.

Most migrants have no knowledge of how diseases are spread, and many sick individuals may be walking around with chickenpox, mumps, measles, diabetes or heart trouble. They go to clinics only when they "feel" sick. They might know that immunizations are good for their children, but few migrants make an effort to have their children receive

A Problem for Hospitals

There is no broad hospitalization program. Sometimes hospitals refuse to admit a migrant because he cannot pay. Those hospitals that do admit migrants frequently have to absorb the cost of caring for them because of the lack of a hospitalization plan and the low income of migrants. One private hospital had to take a $60,000 loss because migrants were not able to pay for medical help. One migrant, who had a lengthy stay in one hospital, was able to pay only $1.50 on a $2300 medical bill. In community hospitals, these losses are passed on to the taxpayers; patients are sometimes charged more in private hospitals to make up the loss in caring for migrants.

Migrant project workers and hospital officials hope that federal funds may be released in the future to pay migrants' hospital bills.

Some of the services available to migrants in most counties include:

Prevention of Disease

by immunizations, prenatal and postpartum care, physical examinations, advice on nutrition and child spacing, cancer cytology examinations, chest X rays, laboratory services, mental health care, nursing follow-up, epidemiological services, health education and protection in housing and sanitation;

Treatment of Diseases

such as tuberculosis, venereal diseases, intestinal parasites, rheumatic fever and diabetes, minor and emergency treatment of accidents and nursing care for the sick in the home;

Rehabilitation

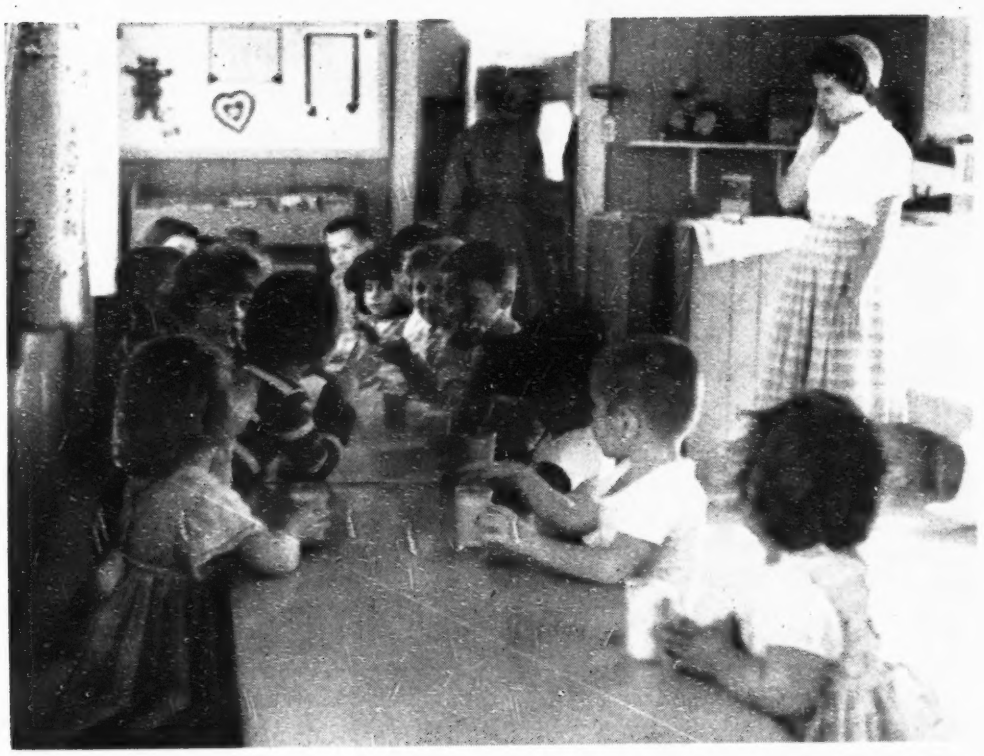
of adults through vocational guidance and help for crippled children.

the necessary polio, tetanus, whooping cough, diphtheria and smallpox inoculations.

Migrants may not seek health services because the various states in which they work may offer different services or none at all. Where one state may send public health nurses to the camps to assist the migrants in seeking health services, another state in which they work may make no provisions for their health. These situations can confuse the migrants, and they give up and do not seek medical or welfare assistance.

TODAY'S MIGRANT HEALTH PROJECT

In 1964, the State Board of Health received federal funds to start a statewide assistance project for migrants. Thirteen counties, which have approximately 40 per cent of the migrants (Alachua, Broward, Collier, Highlands, Glades, Hendry, Lee, Orange, Polk, Manatee, Sarasota, Putnam and Flagler) are participating in the project. Dade and Palm Beach Counties, with an additional 35 per cent of the migrant population, have their own projects supported in part by the Children's Bureau and the U. S. Public Health Service.



The Christian Migrant Ministry operates a day care center for children in Immokalee (above) while the Salvation Army, in cooperation with other volunteer organizations, runs a similar facility in Belle Glade (left).

The federal funds provide personnel—public health nurses, physicians, sanitarians, health educators, social workers, nutritionists and clinic-aides. Also, equipment and medications are furnished and physicians' and dentists' fees are paid in areas where clinics are not available.

Clinics for migrants are held at a variety of places—in churches and trailers, at packing houses and camps—or even in the open field. Many are combination clinics with well-baby, prenatal, postpartum, immunization and general health services being given at one time. Night clinics are scheduled in rural areas where migrants cannot leave their work during the day to seek medical help. Emergency dental services are available in some counties.

NURSES AND SANITARIANS

The two classes of public health workers that have the most direct contact with the migrants are the nurses and sanitarians.

During a single day a **public health nurse** may give immunizations to a group of children, read a tuberculosis skin test, arrange a chest X ray, give advice on child spacing to a young mother with too many children, visit a sick migrant in his quarters, send a stool specimen to the regional laboratory, discuss with the sanitarian the problems of a camp where diarrhea has been occurring, treat a cut hand, consult with the County Health Officer about a migrant woman who has been diagnosed as having cervical cancer and a hundred and one other similar duties.

The **sanitarian** carries on a continual campaign for better housing and sanitary facilities. Because good private housing is hard to find in a rural community, migrants often move into condemned housing once the sanitarian's back is turned. These shacks are usually built of rough lumber or tarpaper, surrounded by piles of rubbish and infested with in-

sects and rodents. If sanitary facilities are available, they usually consist of a rough privy and there is no place to take a shower or bath. Drinking water frequently comes from a rusty pump.

THE GROWERS' AND COMMUNITIES' RESPONSIBILITIES

While the growers make their profits directly from the crops harvested by the Miggs and other migrants, some of them feel they have no responsibility for the workers nor do they have a high regard for migrants as human beings. Efforts are being made by the County Health Departments, the State Board of Health and other agencies and organizations to persuade the growers to view healthy migrants as a financial investment. When migrants are in poor health, the growers can lose many man-hours at a time when their crops are ready to harvest. Migrants who have pleasant and healthy surroundings, medical care and good relationship with their employers, work better, are happier and can produce more for the grower.

Some growers take an active interest in the people who work for them. Others feel that they need only to provide the migrants with housing—and then they have met their obligations. Because of the shortage of housing or quarters (which may not meet minimum standards of the Sanitary Code) and the attraction of city living, more migrants are moving from farm camps into the neighboring communities.

Some communities can absorb a certain number of migrants but the influx of many thousands of persons puts a strain on migrant-community relations. Some communities have established housing for migrants by the use of federal funds. Other communities have made no effort to provide good housing in any quantity.

THE HEALTH INDEX REFERRAL SYSTEM

An important part in providing health assistance to the migrant is knowing what services he has received in other states or County Health Departments. If Mrs. Miggs (the migrant woman in our story) is ex-

Frequently the public health nurse has to visit the migrant laborer's home to make sure his family received the necessary medical care.

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pecting a baby, she may be seen at a prenatal clinic in New York State. The physician and public health nurse in Florida may wish to know what health services she received "up stream" and Mrs. Miggs, because of the lack of education, is unable to tell them.

Different systems of transferring information on health services have been tried. The U. S. Public Health Service uses a health card system but the migrants often lose the cards en route to their next destination. The Florida State Board of Health has developed the Health Service Index Referral System which can transfer health service information from one health department to another without burdening the migrants with carrying messages or health records.

Most migrants know the names of the city or town and the state to which they are moving and approximately when they are going. By using a system developed from the Zip Code of the U. S. Post Office Department, a public health worker in New York State can send information to the health department in the Florida city to which Mrs. Miggs is moving. Mrs. Miggs is given a card telling her to go to the County Health Department when she arrives at her destination. If she loses the card, the migrant woman can go to the post office and ask where the health department is located.

If Mrs. Miggs fails to show up at the health department within a specified time, the public health nurses, who will have received the information from New York State by mail, will start to look for Mrs. Miggs to make sure that she continues her prenatal care. This system fails only when Mrs. Miggs moves to another community other than the one to which she had intended.

HELP FOR THE ASKING

Florida is providing more and more health services for migrant laborers, but until the migrants avail themselves of the services they will not realize the benefits of good health.

It is certain that the Miggs possess some of the same health problems they had as permanent residents of a community. These problems were brought into the migrant stream and complicated by the nomadic way of life. The Miggs differ from Florida's permanent residents of the lower socioeconomic level only in that they are less aware that there are answers to their problems.

The Miggs and other migrants must be educated so they can understand their problems and better the situations in which they find themselves. The aim of the migrant project is to provide the same health services for this special group that are furnished permanent low income residents of the state. It is hoped that with better health, the migrants can become more productive people with an improved way of life.

An open campfire may be the only place to cook in a tent camp (right) and sanitary facilities may consist of pit privies (opposite page).

Since the program began, infant deaths among migrants in one project county dropped from 12 deaths to one in a year's time, probably because of better health care for mothers and children.

The migrants spend six to eight months in Florida each year. During this extended time, the state has more opportunity to help these people than the other states of the migrant stream. Since part of our economy is dependent upon the labor they perform, we are obligated to help them to better health and a better way of life.

Migrant Health Coordination

A former sanitarian is working as a migrant health coordinator to bring together the health activities of the State Board of Health and the County Health Departments with the work of other agencies and organizations which are involved in helping the migrants. This work includes:

keeping the federal and other state agencies and lay organizations informed of the progress of the migrant project,

maintaining close contact with the County Health Departments to make sure they hold to the requirements of the migrant health project,

making new counties which come into the project aware of the expanded services they can offer migrants, and

sustaining a continuity of health services throughout the state.

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